

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8 2 2 9 5 2 1				
					REG. NO.				
1 - FOR STATE REGISTRAR	FIRST	MIDDLE	LAST						
1a DECEASED NAME (TYPE OR PRINT)	Tsacc William Goldsborogh			2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
3 SEX	4 RACE	5 DATE OF BIRTH MONTH DAY YEAR		November 16, 1982				M	
Male	Black	June 19, 1907		6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Maryland	USA			Kent				MD.	
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b KIND OF BUSINESS OR INDUSTRY	
Chestertown	At Home			Labor				Various	
13a STATE Maryland					13b COUNTY Kent	13c CITY OR TOWN Chestertown	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS 428 Calvert Street	
14 FATHER'S NAME FIRST Green					MIDDLE	LAST Goldsborogh	15. MOTHER'S MAIDEN NAME FIRST Virginia	MIDDLE	LAST
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	16c INFORMANT Mrs. Rosie Goldsborogh	ADDRESS 428 Calvert St Chestertown, Md.						
No	—								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4100 Acute Myocardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerosis (Heart Disease)</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>									
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET	CITY OR TOWN	COUNTY	STATE				
22a I certify that (I) (this hospital) attended the deceased from <i>7/10/82</i> , 19_____, to <i>19_____</i> , 19_____, that (II) (we) last saw the deceased alive <i>7/10/82</i> , 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Kin Kue Wun M.D.</i>	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>11/16/82</i>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e ADDRESS Chestertown, Maryland 21620								
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 1/20/1982	23c NAME OF CEMETERY OR CREMATORIAL Rich Neck Hall	23d. LOCATION CITY OR TOWN Chestertown	23e. COUNTY Q.A. Md.	STATE				
24. FUNERAL DIRECTOR NAME <i>Jennifer W. Day</i>	ADDRESS Chestertown, Md.	25e. DATE REC'D. BY REGISTRAR NOV 18 1982			25b. REGISTRAR'S SIGNATURE <i>John J. Coniff</i>				



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 through 3 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2	2 9	5 2	2
										REG. NO.			
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR P		
		WARREN C. JACOB					Nov. 27, 1982				9:30 M		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
male		white		12/15/1920			61						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Kent				MD.		
Kent Co. Md.		USA											
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) RFD # 2 At Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer				12b. KIND OF BUSINESS OR INDUSTRY various					
13a. STATE Md.		13b. COUNTY Kent		13c. CITY OR TOWN Chestertown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS RFD # 2 Bx 508					
14. FATHER'S NAME FIRST: Charles F. Jacob		MIDDLE: LAST:		15. MOTHER'S MAIDEN NAME Edith Wheat									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. WW 2		17. INFORMANT Bernice Jacob				ADDRESS RFD # 2 Box # 508 Chestertown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										<i>Possible Acute myocardial infarction</i>			
DUE TO, OR AS A CONSEQUENCE OF (b)										<i>H. AS CVD</i>			
DUE TO, OR AS A CONSEQUENCE OF (c)										<i>Svag. C.v.P.D.</i>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET				CITY OR TOWN		COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 11/25 1982 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		19 82		11/27/1982				11/27/1982					
22b. SIGNATURE <i>Patricia Molony</i>		DEGREE <i>Lu. A.</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>11/28/82</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Patrick A. Molony		22e. ADDRESS Chestertown, Md.											
23a. BURIAL, CREMATION, REMOVAL SPECIES Burial		23b. DATE 12/1/82		23c. NAME OF CEMETERY OR CREMATORIUM Wesley Chapel Cem.				23d. LOCATION Rock Hall, Md.					
24. FUNERAL DIRECTOR NAME <i>Willis Wells</i>		ADDRESS Chestertown, Md.		25a. DATE REC'D. BY REGISTRAR DEC 2 1982				25b. REGISTRAR'S SIGNATURE <i>James C. Cawie</i>					



16500 300

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												82 29523			
												REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2d. HOUR			
<i>Madelyn S. Johnson</i>						11			11	82		11 AM			
3. SEX			4. RACE	5. DATE OF BIRTH	MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS HOURS			
F			W	6 29 01	28	81	YRS.	7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			8. CITIZEN OF WHAT COUNTRY?				
Chesapeake City			USA	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH				
Chester Town			Magnolia Hall			KEMT			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
Md.			Cecil	Chesapeake City			12b. KIND OF BUSINESS OR INDUSTRY			Housewife			HOME		
14. FATHER'S NAME			FIRST	MIDDLE	LAST	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			14. FATHER'S NAME			
BENNETT				STEEL		15. MOTHER'S MAIDEN NAME			216 Pulaski Hwy, Elkton			CONREY			
16d. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			16c. WAR OR DATES			
NO			221-18-7810A			MARGORIE AUSTIN			WARRICK MD			4850 MARJORIE AUSTIN			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>BRONCHOPNEUMONIA</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days			
DUE TO, OR AS A CONSEQUENCE OF (b) <i>ASCVD, chronic bronchitis</i>															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>ASCVD, chronic bronchitis</i>															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE			
22a. I certify that (I) (his hospital) attended the deceased from <i>10-20 1982</i> , to <i>11-11 1982</i> , that (I) (we) lost saw the deceased alive on <i>11-7 1982</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED <i>11-11-82</i>			
22b. SIGNATURE <i>Harry P. Ross, MD</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>HARRY P. ROSS</i>			22e. ADDRESS <i>CHESTERTOWN, MARYLAND</i>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>			23b. DATE <i>11-16-82</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>BETHEL</i>			23d. LOCATION CITY OR TOWN <i>CHESAPEAKE CITY, CECIL</i>			23e. COUNTY STATE			
24. FUNERAL DIRECTOR NAME <i>Robert J. Foard</i>			ADDRESS <i>CHESAPEAKE R.T. FOARD FUNERAL HOME CITY MD</i>			25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <i>NOV 18 1982 John J. Conwell</i>									

Forces of movement against

ASCD) compression

X

- 58

11-11

- 58

- 24-01

- 58

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59-11-11

X

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W.W.

11

11

CHESTERFIELD, MICHIGAN

HARRY B. BROWN

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY PLEASE EXECUTE THE CERTIFICATE WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 1 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL/TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 3 2 2 9 5 2 4
1- FOR STATE REGISTRAR			2a. DATE KNOWN <input checked="" type="checkbox"/> MONTH 11 DAY 13 YEAR 1982 HOUR 50 AM									
1. DECEASED NAME (TYPE OR PRINT)			FIRST GLADYS			MIDDLE LIVELY			2c. DATE PRONOUNCED DEAD MONTH 11 DAY 13 YEAR 1982 HOUR 50 PM			
3. SEX <b>female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5/10/1926</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>56</b> YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Q.A. Co. Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Kent</b>						
10. CITY OR TOWN OF DEATH <b>Chestertown</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>At Home Washington Park</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Domestic</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Md.</b>		13b. COUNTY <b>Kent</b>		14. CITY OR TOWN <b>Chestertown</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>RFD Washington Park</b>				
14. FATHER'S NAME FIRST <b>Harvey</b>		MIDDLE <b>Johnson</b>		LAST		15. MOTHER'S MAIDEN NAME FIRST <b>Gertrude</b>		MIDDLE <b>Griffin</b>		LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>213 22 9049</b>		17. INFORMANT <b>Charles Lively</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>4149</b> IMMEDIATE CAUSE (a) <i>arteriosclerotic CVSD</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <i>probable coronary artery disease</i> DUE TO, OR AS A CONSEQUENCE OF (c)		19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Diabetes Mellitus</i>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE			
22a. I certify that I am in charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <i>Robert W. Farr</i> TITLE (SPECIFY) <i>Deputy</i> M.D. MEDICAL EXAMINER EXAMINER'S NAME (TYPE OR PRINT) <b>Robert W. Farr</b> ADDRESS <b>Chestertown, Md. 21620</b>												
23a. BURIAL, CREMATION, REMOVAL SPECIFY <b>Burial</b>			23b. DATE <b>11/17 /82</b>			23c. NAME OF CEMETERY OR CREMATORIUM <b>Chesterfield Cemetery</b>			23d. LOCATION CITY OR TOWN <b>Centreville, Md.</b> COUNTY <b>St. Mary's</b> STATE			
24. FUNERAL DIRECTOR NAME <i>James Perkins</i>			ADDRESS <b>Rock Hall, Md.</b>			25. REC'D. BY REGISTRAR <i>John J. Conroy</i> REGISTRAR'S SIGNATURE <b>NOV 18 1982</b>						
DHMH - 17 FVR A15 ME (51) 15M 7/76												

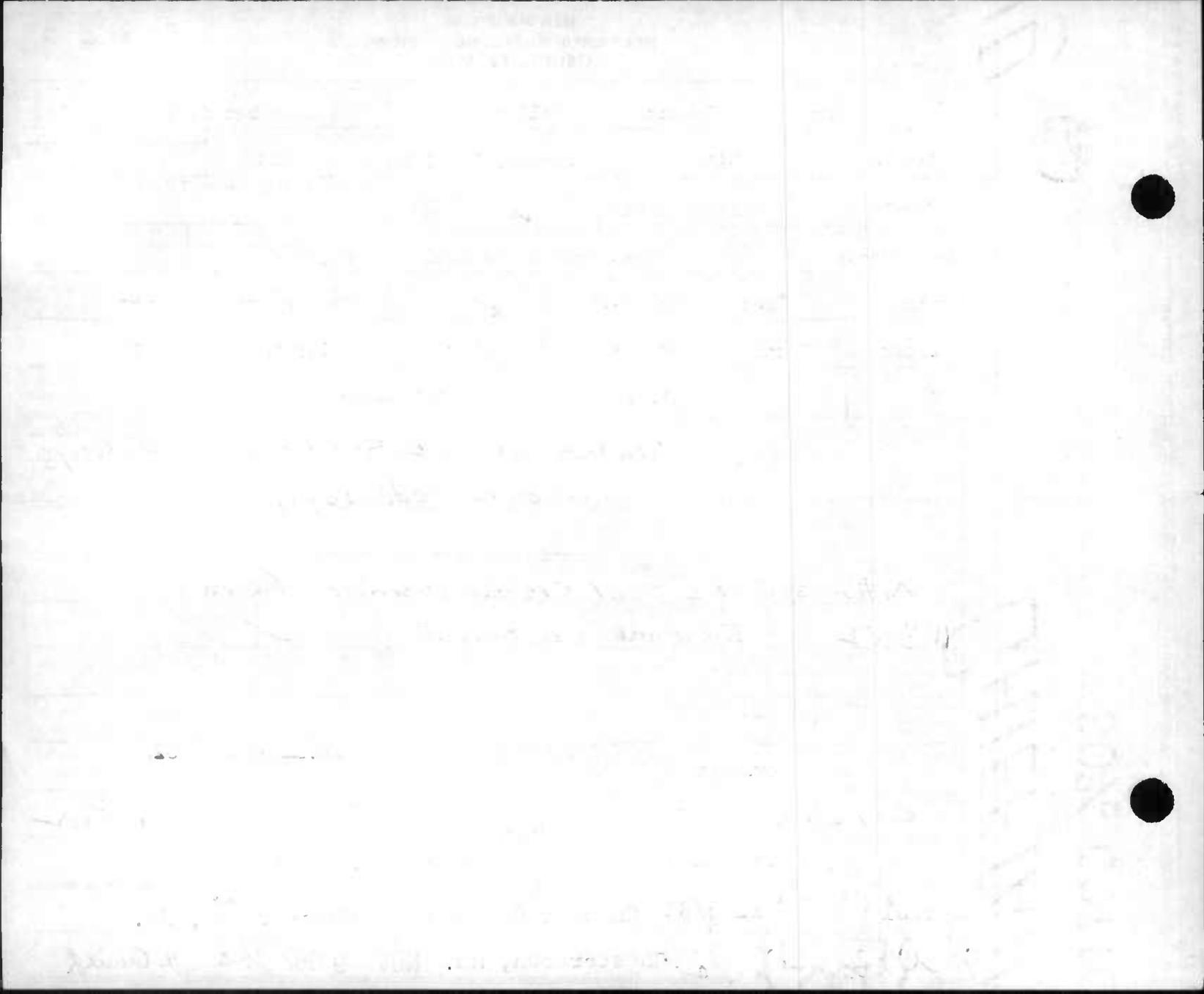
388 81 104

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IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 9 5 2 5		
										REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
Ann			Rebecca		Loller	November		5,	1982		8:20a M	
3. SEX <b>Female</b>			4. RACE <b>White</b>			5. DATE OF BIRTH MONTH <b>December</b> DAY <b>14</b> YEAR <b>1892</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b> <b>93X</b> YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Kent</b>			
10. CITY OR TOWN OF DEATH <b>Chestertown</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Kent &amp; Queen Anne's Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Kent</b>		13c. CITY OR TOWN <b>Rock Hall</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>Stoops Trailer Court</b>				
14. FATHER'S NAME FIRST <b>Walter</b> MIDDLE <b>Horace</b> LAST <b>Stokes</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Clara</b> MIDDLE <b>Elizabeth</b> LAST <b>Ashley</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>212-74-4712</b>			17. INFORMANT <b>Hospital Records</b>			ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intestinal Obstruction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>5609</b> (b) <b>atherosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c) <b>atherosclerosis</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Arteriosclerotic and cerebral vascular disease</b>												
19a. DATE OF OPERATION <b>11-3-82</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Intestinal obstruction</b>			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>October 31</b> , 19 <b>82</b> , to <b>November 5</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>November 5</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE 			22c. DEGREE <b>MD</b>			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED <b>11/5/82</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>C. Gottfried Baumann</b>			22e. ADDRESS <b>Chestertown, Md. 21620</b>									
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>			23b. DATE <b>11/8/82</b>			23c. NAME OF CEMETERY OR CREMATORIAL <b>Chester Cemetery</b>			23d. LOCATION CITY OR TOWN <b>Chestertown, Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Willis Wells</b>			ADDRESS <b>Chestertown, Md.</b>			25a. DATE REC'D. BY REGISTRAR <b>NOV 9 1982</b>			25b. REGISTRAR'S SIGNATURE 			

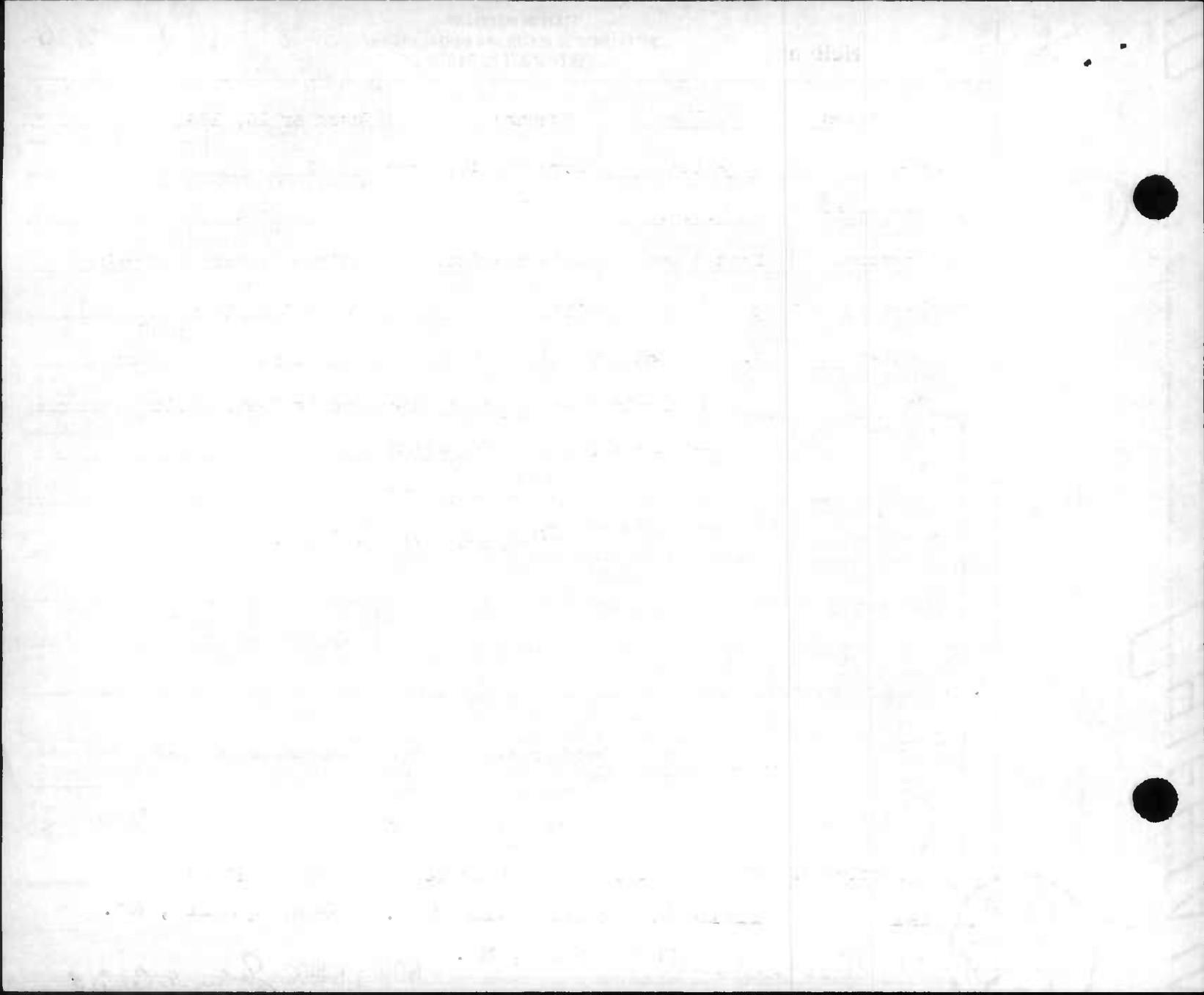


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the deceased has been signed by the attending physician and completely filled in by him.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon papers. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

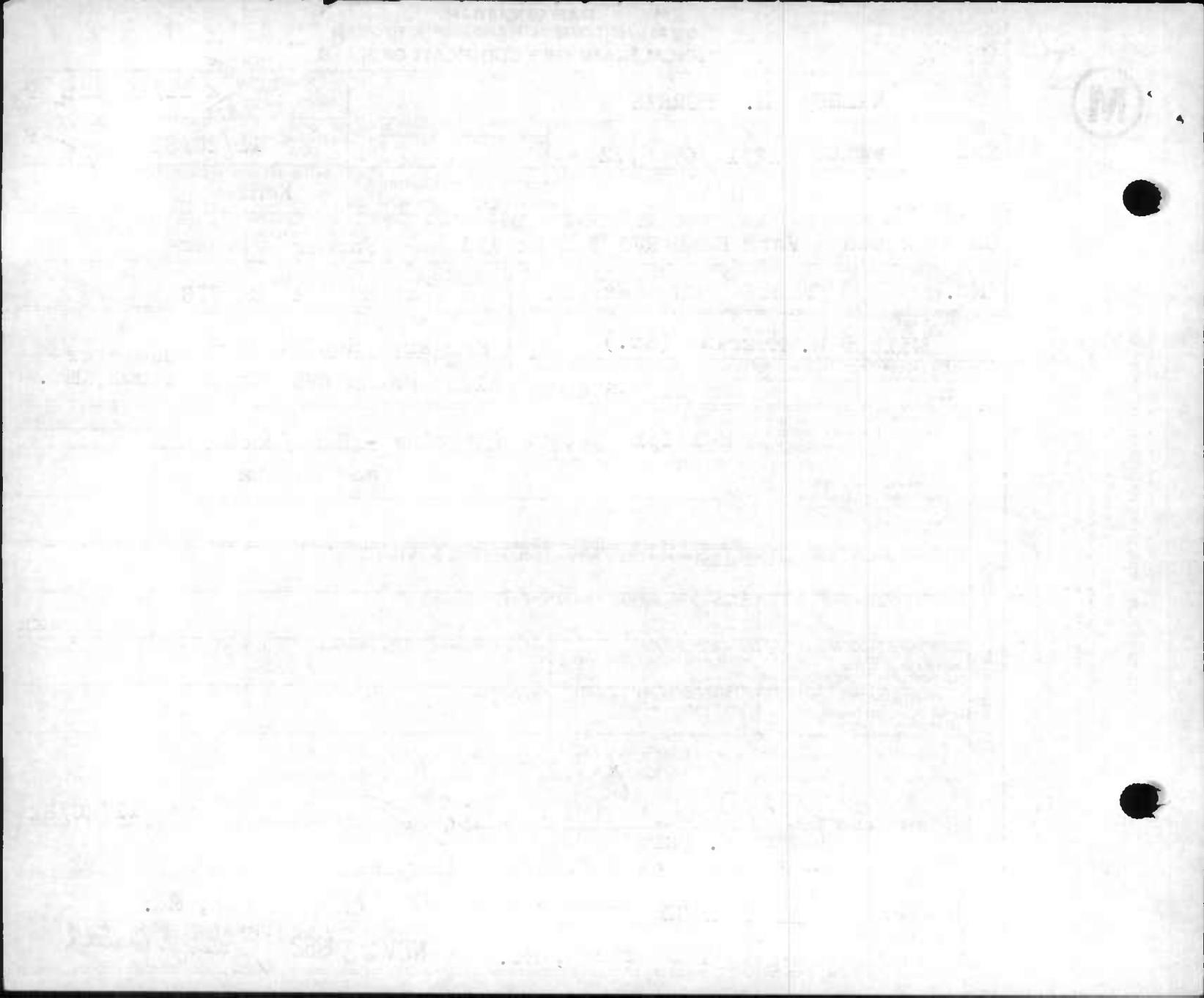
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 9 5 2 6						
										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR				
Joseph			Alban		Mchenry	November 10, 1982						8:45 PM				
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
Male		White		MONTH DAY YEAR			82			MONTHS	DAYS	HOURS	MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH									
Pennsylvania		U.S.A.		November 18, 1899			Kent			MD.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
Chestertown		Kent & Queen Anne's Hospital		Retired Farmer			Farming									
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
Maryland		Kent		Kennedyville			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		General Delivery							
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			16. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
		Allen	Z.	Mchenry	Ella					Blance			DERR			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT					ADDRESS							
No		217-16-9483		Kent & Queen Anne's Hosp. Medical Records												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) - CARDIAC ARREST. 4292										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) - (c) DUE TO, OR AS A CONSEQUENCE OF ASCVD - DUE TO, OR AS A CONSEQUENCE OF CARDIOPULMONARY SHOCK.																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from October 13, 1982, to November 10, 1982, that (I) (we) last saw the deceased alive on November 10, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED 11/11/82						
22b. SIGNATURE Patrick A. Molony		22c. DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>												
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS														
Patrick A. Molony		M.D.		Chestertown, Maryland 21620												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/13/82		23c. NAME OF CEMETERY OR CREMATORIAL Kennedyville Cem.			23d. LOCATION Kennedyville, Md.			STATE						
24. FUNERAL DIRECTOR NAME G. Willis Wells		25a. DATE REC'D. BY REGISTRAR NOV 15 1982		25b. REGISTRAR'S SIGNATURE Jean J. Gould												



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR INFORMATION. PAGE 3 SHOULD BE USED AS A BURIAL TRANSPORT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 3229527	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN DEATH OCCURRED MONTH DAY YEAR			2b. HOUR 19 P.M.				
WILBUR H. MORRIS						11/20 82							
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS.		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.			
Male		white		12/14/09		72							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWE <input checked="" type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH					
Maryland		USA				Kent		Chestertown					
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (UP TO INCL. FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
Farm Home RFD # 2 Bx 758				Farmer									
13a. STATE Md.				13b. COUNTY Kent		13c. CITY OR TOWN Chestertown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rd # 2 Bx 758			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <input type="checkbox"/> no				16b. SOCIAL SECURITY NO. 217 36 0064	
Wilbur H. Morris (Sr.)				Margaret Hendrickson				17. INFORMANT ADDRESS Alice Mason RFD Chestertown, Md.				Daughter	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Severe injuries - Head/Neck</b> DUE TO, OR AS A CONSEQUENCE OF 9289 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			21d. LOCATION STREET CITY OR TOWN COUNTY STATE				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f.							
22a. I certify that I took charge of the remains described above, held on <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												TITLE (SPECIFY) M.D. <i>Deputy</i> MEDICAL EXAMINER	
ACTUAL SIGNATURE <i>Robert W. Farr</i>		EXAMINER'S NAME (TYPE OR PRINT) Robert W. Farr Chestertown Kent County ADDRESS Maryland										DATE SIGNED 11/20/82	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial			11/23/1982			Chester Cemetery			Chestertown, Md.				
24. FUNERAL DIRECTOR NAME <i>Willie Wells</i>			ADDRESS Chestertown, Md.			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE <i>J. Ann J. Conner</i>				
BP						NOV 23 1982							
DHMH - 17 (VR A15 ME 5) 15M 7/76													

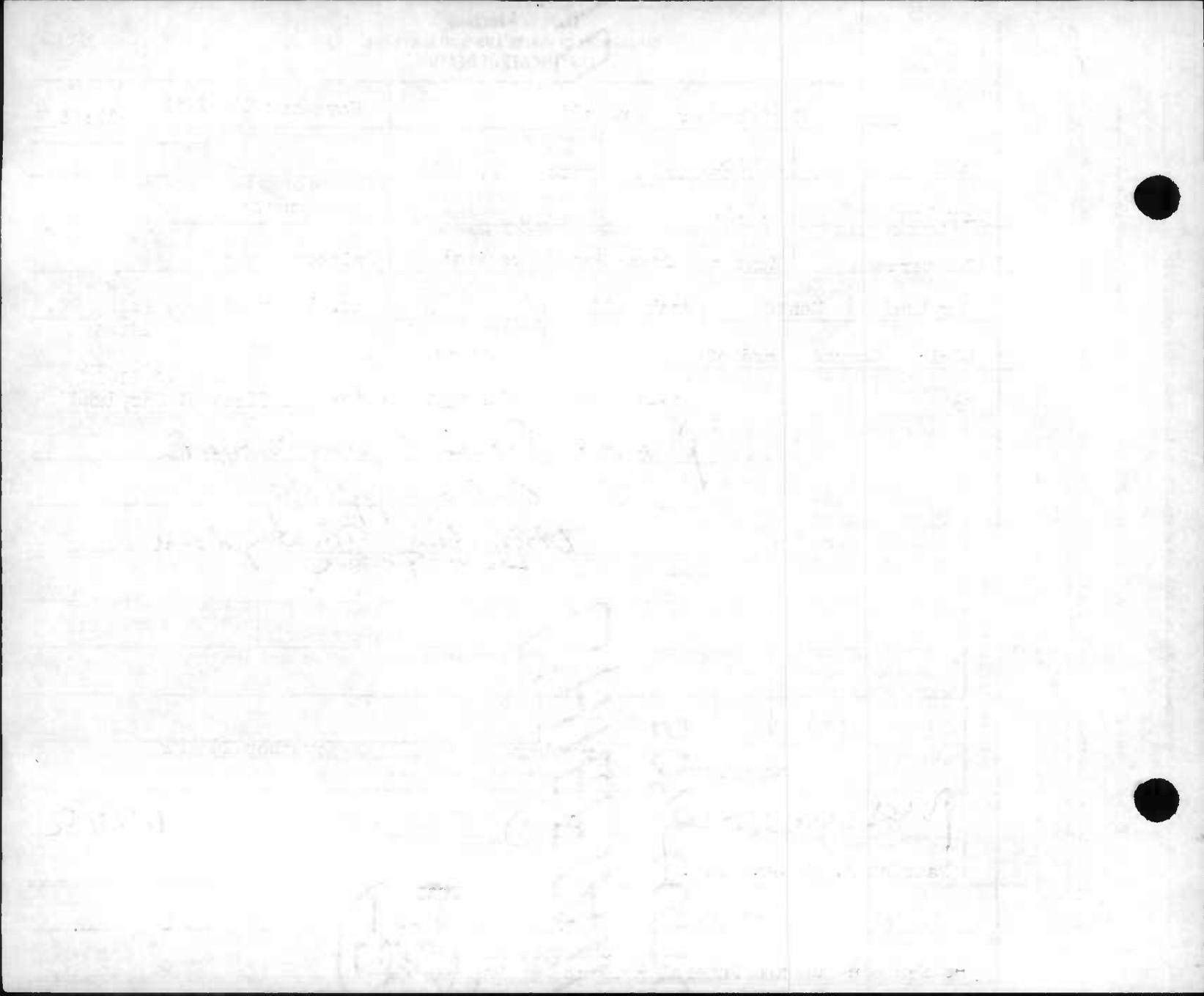


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8229528			
												REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
Otto Christopher Nordhoff						November 24, 1982						11:55 A			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		White		March 27, 1925			57			MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Maryland		U.S.A.					Kent County								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Chestertown			Kent and Queen Annes Hospital			Painter									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS							
Maryland		Kent		Rock Hall				Rt. 1 Box 89 Rock Hall, Md.							
14. FATHER'S NAME FIRST			MIDDLE			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			21661 LAST			
Edwin Conrad Nordhoff						Esther Mae Kelley									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT Lillian Audrey Nordhoff			ADDRESS Rock Hall, Md.			Bt. #1 Box 89			
No			218-14-2546			Hospital Records-Chestertown, Maryland									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Possible Acute myocardial infarction</i> <i>4254</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF (b) <i>-Cardiomegaly</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Obstructive coronary disease</i>															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from November 24, 1982, to November 24, 1982, that (I) (we) last saw the deceased alive on November 24, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>McNamee</i>			DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input type="checkbox"/>			MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>11/26/82</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Patrick A. Molony, M.D.			22e. ADDRESS												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11-27-82			23c. NAME OF CEMETERY OR CREMATORIAL Wesley Chapel Cemetery			23d. LOCATION CITY OR TOWN Rock Hall			COUNTY Kent		STATE Md.	
24. FUNERAL DIRECTOR NAME Helfenbein-Hubbard Funeral Home			ADDRESS Chester, Md. 2166B			25a. DATE REC'D. BY REGISTRAR DEC 3 - 1982			25b. REGISTRAR'S SIGNATURE <i>John J. Carroll</i>						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

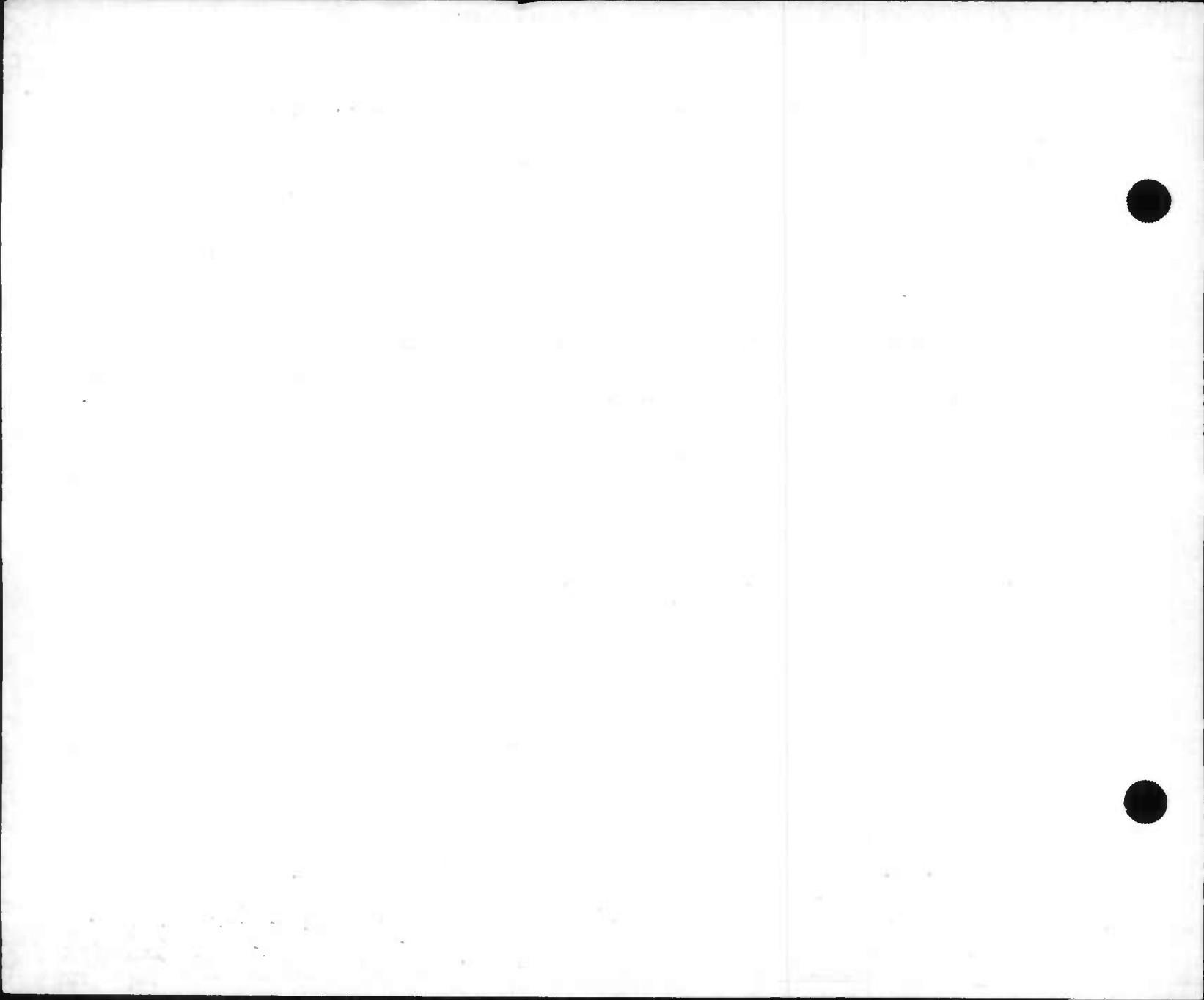
Page 4 may be

referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon paper, pages 1 and 2, should be filed within 72 hours of the death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 82 29529							
1 - STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR Nov. 3, 1982							2b. HOUR 7:49 P.M.							
1. DECEASED NAME (TYPE OR PRINT) Margaret "Peggy" PERKINS			MIDDLE LAST			5. DATE OF BIRTH MONTH DAY YEAR 27/25/1898			6. AGE (IN YEARS LAST BIRTHDAY) 84		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.				
3. SEX female			4. RACE white			9. BALTIMORE CITY OR COUNTY OF DEATH Kent			10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) At Home RFD Quaker Neck			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Real Estate Broker Retired			
13a. STATE Maryland			13b. COUNTY Kent			13c. CITY OR TOWN Chestertown			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS RFD Quaker Neck			12b. KIND OF BUSINESS OR INDUSTRY			
14. FATHER'S NAME William Whitmore			LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Lyles											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO 049 14 1436			17. INFORMANT Nancy Bulkeley			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASCVD</u> <u>4292</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			ADDRESS RFD Quaker Neck Chestertown, Md.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>15 years</u>		
MEDICAL CERTIFICATION			19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
			21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
			21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (the hospital) attended the deceased from <u>6-10</u> , 19 <u>82</u> , to <u>11-3</u> , 19 <u>82</u> , that (I) <input type="checkbox"/> last saw the deceased alive on <u>Oct 29</u> , 19 <u>82</u> , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			22b. SIGNATURE <u>A. C. Dick</u>			22c. DEGREE ATTENDING <input checked="" type="checkbox"/> MEDICAL PHYSICIAN <input type="checkbox"/> STAFF DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <u>11/3/82</u>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. C. Dick			22e. ADDRESS Chestertown, Md. 21620														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 11/4/82			23c. NAME OF CEMETERY OR CREMATORIALy Silverbrook Crematory			23d. LOCATION CITY OR TOWN COUNTY STATE Wilmington, Del.			25. DATE REC'D. BY REGISTRAR NOV 9 1982					
24. FUNERAL DIRECTOR NAME <u>Willie Wells</u>			ADDRESS Chestertown, Md.			26. REGISTRAR'S SIGNATURE <u>John J. Conroy</u>											
DHMH-16 20M (VRA 15, 4) 7/78																	

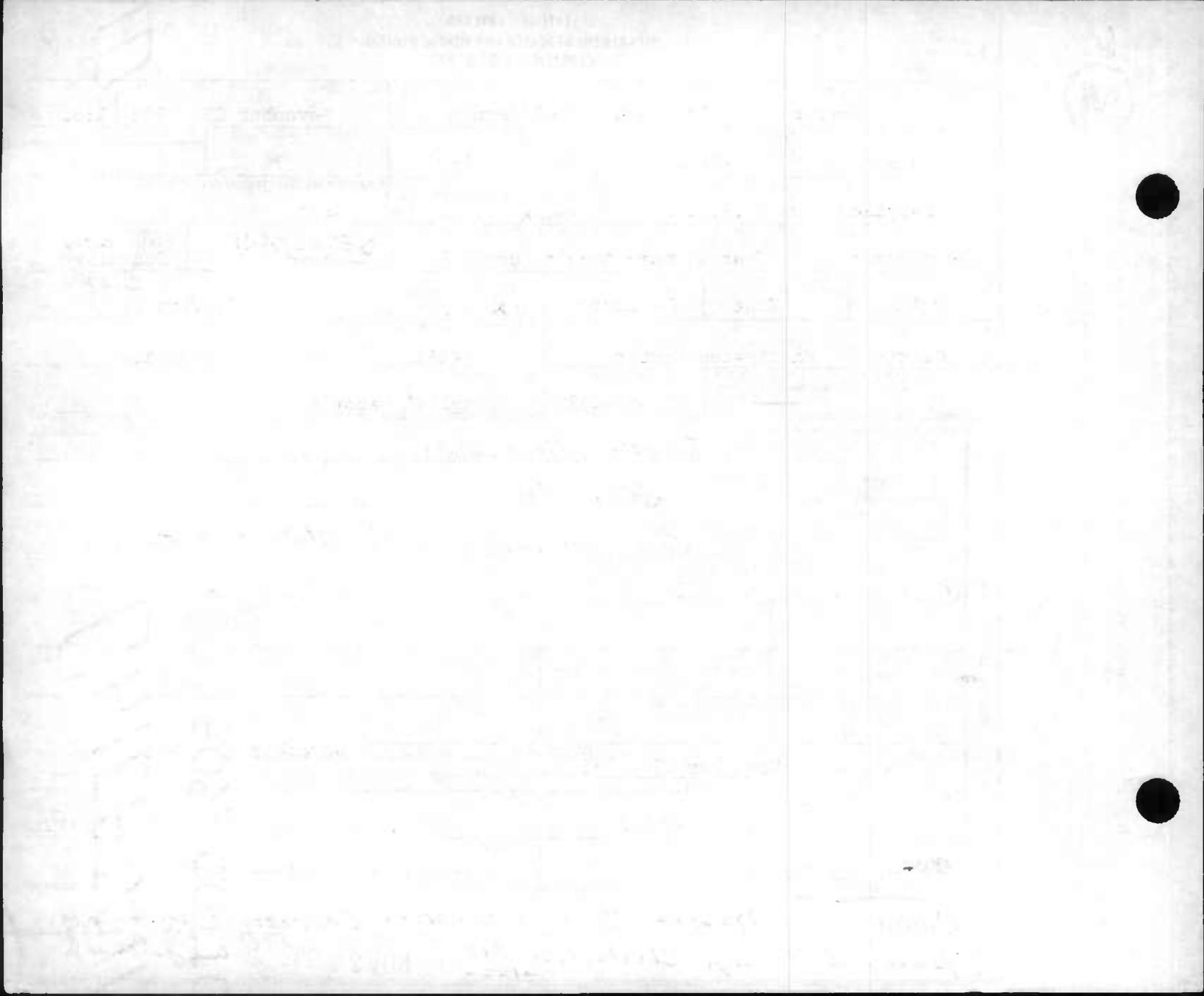


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of other death. Page 4 must be signed by the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										82 29530					
										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
Martha Elizabeth Rollison						November 23, 1982						1:32p m			
3. SEX Female			4. RACE White			5. DATE OF BIRTH April 9, 1908			6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Kent			MD.			
10. CITY OR TOWN OF DEATH Chestertown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent & Queen Anne's Hospital			12a. USUAL OCCUPATION Retired			12b. KIND OF BUSINESS OR INDUSTRY Secretary						
13a. STATE Maryland			13b. COUNTY Kent			13c. CITY OR TOWN Chestertown			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS P.O. Box 73		21620	
14. FATHER'S NAME FIRST George			MIDDLE Washington Carter			15. MOTHER'S MAIDEN NAME FIRST Nettie			MIDDLE Mae			LAST Passwater			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. No			17. INFORMANT Hospital Records			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock, Hemorrhage</u> 4912 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Stress ulcer</u> (c) <u>Laryngotracheobronchitis, status asthmaticus</u> .															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 ① Chronic obstructive pulmonary disease ② Generalized arteriosclerosis.															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from November 18, 1982, to November 23, 1982, that (I) (we) last saw the deceased alive on November 23, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.												22c. DATE SIGNED 11/23/82			
22b. SIGNATURE <u>Kin Kue Wun, MD.</u>			22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Kin Kue Wun			22e. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 11/26/82			23c. NAME OF CEMETERY OR CREMATORIAL CHESTER CEMETERY			23d. LOCATION CITY OR TOWN CHESTERTOWN			COUNTY KENT	STATE Md.		
24. FUNERAL DIRECTOR NAME Marvin V. William Jr.			25a. DATE REC'D. BY REGISTRAR NOV 29 1982			25b. REGISTRAR'S SIGNATURE John J. Conroy									
BP _____															
DHMH - 16 50M 4/B2 (VRA 15, 4)															



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 9 5 3 1						
										REG. NO.						
1 - FOR STATE REGISTRAR			FIRST			MIDDLE			LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)			Annie			Mae			Shelton			November 12, 1982			11:53 A	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female			white			MONTH DAY YEAR			July 30 1923			59		YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
Maryland			U.S.A.									Kent County				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Chestertown			the Kent and Queen Anne's Hospital			Disabled										
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS				
Maryland			Kent			Chestertown						Morgnec Village Apt 8-B				
14. FATHER'S NAME			FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME										
William Bryon			Price			Bernice Ruth Renel										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS							
No			462-22-0219			Hospital Records--Chestertown, Maryland										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
Shock										52						
5700 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) acute hepatic necrosis																
DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.																
renal insufficiency																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from November 11, 1982, to November 12, 1982, that (I) (we) last saw the deceased alive on November 12, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE			Thomas J. Solon, M.D.			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			Thomas J. Solon, M.D.			22e. ADDRESS			Chestertown, Maryland 21620			11-15-82				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL LOCATION			23d. LOCATION TOWNSHIP COUNTY STATE							
Burial			11/15/82			St. Clement's Cem.			Massey, Maryland							
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
Willis Wells			Chestertown, Md.			NOV 16 1982			John J. Coniglio							

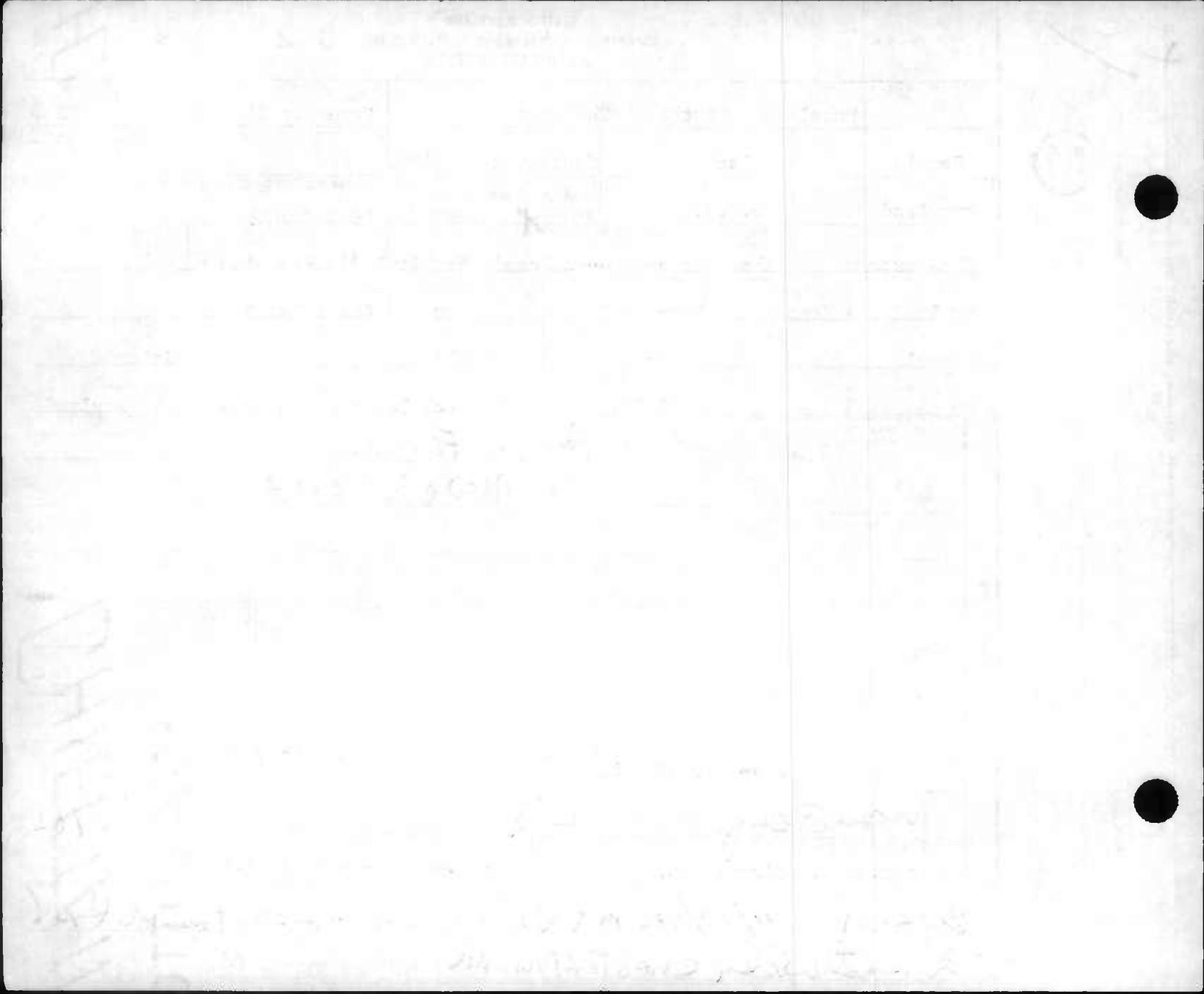


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 9 5 3 2
										REG. NO.
1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
Mabel	Martha	Thompson		November 21, 1982				6:13A M		
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)					
Female	Black	MONTH	DAY	YEAR	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Kent County				
10. CITY OR TOWN OF DEATH Chestertown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Kent and Queen Anne's Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife						
13a. STATE Maryland	13b. COUNTY Kent	13c. CITY OR TOWN Rock Hall	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Rt. 1 Box 33				
14. FATHER'S NAME FIRST Lemeul	MIDDLE	LAST Cann	15. MOTHER'S MAIDEN NAME FIRST Martha			MIDDLE	LAST Wickes			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. No -	17. INFORMANT			ADDRESS 21620 Hospital Records - Chestertown, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DOUE TO, OR AS A CONSEQUENCE OF (b) DOUE TO, OR AS A CONSEQUENCE OF (c)  PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from November 13, 1982, to November 21, 1982, that (I) (we) last saw the deceased alive on November 21, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Patrick A. Molony		DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 11/22/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Patrick A. Molony, M.D.		22e. ADDRESS Chestertown, Maryland 21620								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) B.I.R.P.		23b. DATE 11/27/1982		23c. NAME OF CEMETERY OR CREMATORIAL Mt Pleasant		23d. LOCATION CITY OR TOWN Chestertown		COUNTY Kent	STATE Md	
24. FUNERAL DIRECTOR NAME Brenda L. Molony		ADDRESS Chestertown MD		25a. DATE REC'D. BY REGISTRAR NOV 26 1982		25b. REGISTRAR'S SIGNATURE See attached				

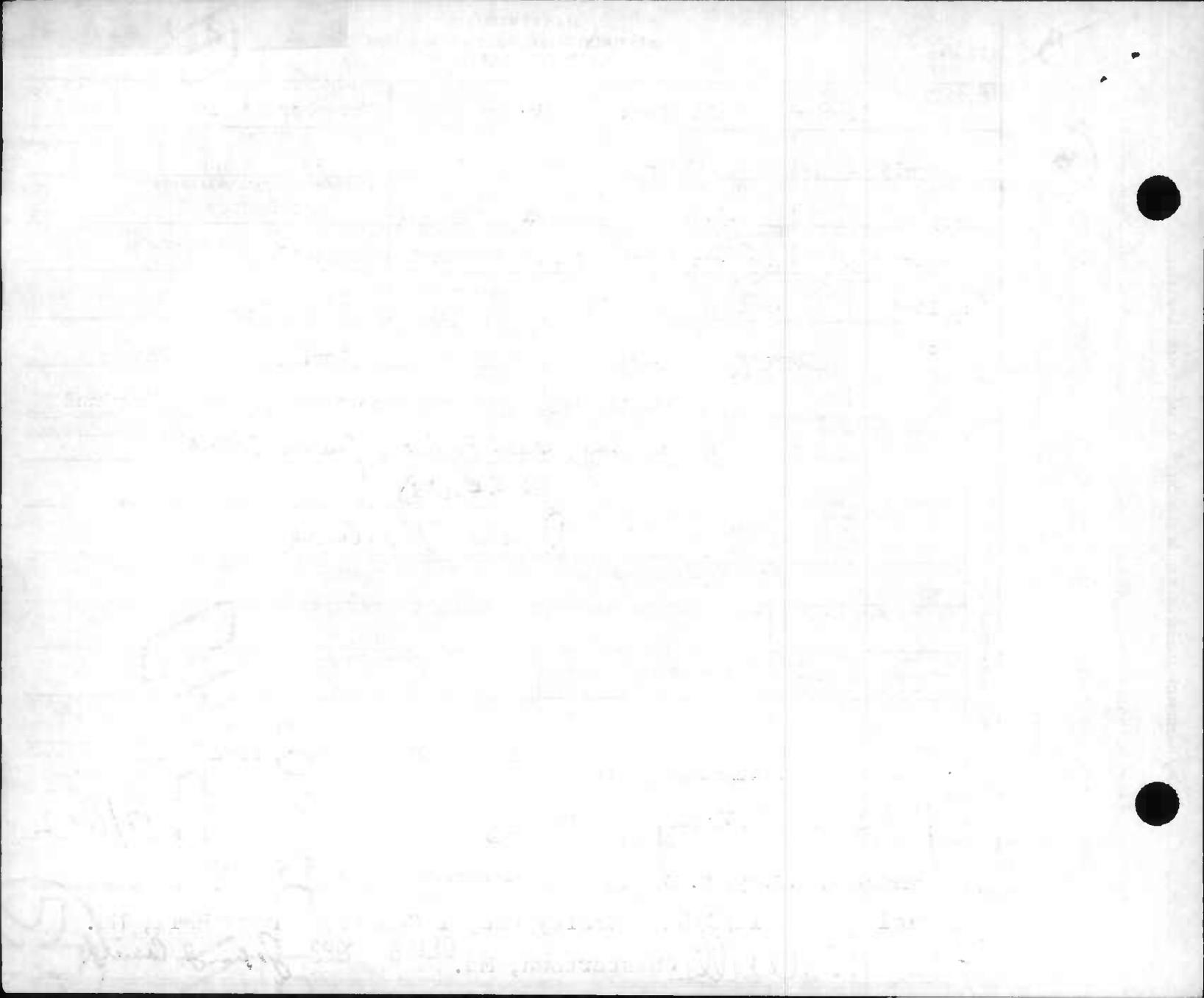


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												82 29533								
												REG. NO.								
1. DECEASED NAME [TYPE OR PRINT] <b>Bertha Elizabeth Watson</b>												2a. DATE OF DEATH <b>November 30, 1982</b>	MONTH DAY YEAR	2b. HOUR <b>3:05 P.M.</b>						
3. SEX <b>Female</b>												4 RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>January 2, 1903</b>	6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS <b>79 yrs.</b>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>												7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Kent County</b>						
10. CITY OR TOWN OF DEATH <b>Chestertown</b>												11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>The Kent &amp; Queen Anne's Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>MD.</b>		
13a. STATE <b>Maryland</b>												13b. COUNTY <b>Kent</b>	13c. CITY OR TOWN <b>Rock Hall</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>Main Street</b>					
14. FATHER'S NAME FIRST <b>Moses</b>												MIDDLE <b>Elsworth</b>	LAST <b>Meekins</b>	15. MOTHER'S MAIDEN NAME FIRST <b>Susan</b>	MIDDLE <b>Louise</b>	LAST <b>Cooper</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>												16b. SOCIAL SECURITY NO. <b>220-14-3163</b>	17. INFORMANT <b>Hospital Records-Chestertown, Maryland</b>			ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>Acute long. heart failure &amp; pulm. edema</b>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
IMMEDIATE CAUSE (a) <b>5860</b>																				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b></b>																				
DUE TO, OR AS A CONSEQUENCE OF (b) <b>A. SCVD</b>																				
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Pulm Failure</b>																				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
YES <input type="checkbox"/> NO <input type="checkbox"/>						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE									
22a. I certify that (I) (this hospital) attended the deceased from <b>November 20, 1982</b> , to <b>November 30, 1982</b> , that (I) (we) last saw the deceased alive on <b>November 30, 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																				
22b. SIGNATURE <b>Patrick A. Molony</b>			22c. DEGREE <b>M.D.</b>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <b>12/11/82</b>											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Patrick A. Molony, M.D.</b>			22e. ADDRESS <b>Chestertown, Maryland 21620</b>																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>12/3/82</b>			23c. NAME OF CEMETERY OR CREMATORIAL <b>Wesley Chapel Cemetery Rock Hall, Md.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE											
24. FUNERAL DIRECTOR NAME <b>J. Willis Wells</b>			ADDRESS <b>Chestertown, Md.</b>			24d. DATE REC'D. BY REGISTRAR <b>DEC 8 1982</b>			25b. REGISTRAR'S SIGNATURE <b>John J. Conroy</b>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death is reported by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 2 2 9 5 3 4	
												REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Melvin Herman Wessel						11-30-82					1982	9:05pm	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Male			White			MONTH DAY YEAR 2 - 23 - 15			67 YRS			IF UNDER 24 HRS MONTHS DAYS HOURS MIN.	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Kent County</b>			MD.	
10. CITY OR TOWN OF DEATH <b>Chestertown</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Kent &amp; Queen Anne's Hospital, Inc.</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Farmer</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>				
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Kent</b>		13c. CITY OR TOWN <b>Chestertown</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS <b>Rt. 1, Box 816X</b>				
14. FATHER'S NAME FIRST <b>Edward</b>			MIDDLE <b>August</b>			LAST <b>Wessel</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Margaret</b>			MIDDLE <b>Henrietta</b>	LAST <b>Zeltman</b>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>215-34-7811</b>			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4360</b>			DOUE TO, OR AS A CONSEQUENCE OF (b) <b>OLD STROKE + CHRONIC PHLEBITIS</b>			(c)						<b>3 yr</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>DEG. ARTRITIS, DEG. DISC DISEASE, INACTIVITY</b>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART II)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE
22a. I certify that (I) (we) attended the deceased from <b>November 28, 1982</b> , to <b>November 30, 1982</b> , that (I) (we) last saw the deceased alive on <b>November 30, 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>Harry P. Ross MD</b>			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <b>12-1-82</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Harry P. Ross, M.D.</b>			22e. ADDRESS <b>Chestertown, MD 21620</b>										
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>			23b. DATE <b>12/3/82</b>			23c. NAME OF CEMETERY OR CREMATORIAL <b>\$t. Paul's Lutheran</b>			23d. LOCATION CITY OR TOWN <b>Fulton, Md.</b>			STATE	
24. FUNERAL DIRECTOR NAME <b>Willie Wells</b>			ADDRESS <b>Chestertown, Md.</b>			25a. DATE REC'D. BY REGISTRAR <b>DEC 8 1982</b>			25b. REGISTRAR'S SIGNATURE <b>John J. Conard</b>				

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